This article was downloaded by: [North Dakota State University]
On: 27 February 2013, At: 13:54
Publisher: Routledge
Informa Ltd Registered in England and Wales Registered Number: 1072954 Registered office: Mortimer House, 37-41 Mortimer Street, London W1T 3JH, UK

Journal of Feminist Family Therapy
Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/wfft20

Seeking Support: Transgender Client Experiences with Mental Health Services

Kristen E. Benson [a]

[a] Department of Human Development and Family Science, North Dakota State University, Fargo, North Dakota, USA

Version of record first published: 27 Feb 2013.

To cite this article: Kristen E. Benson (2013): Seeking Support: Transgender Client Experiences with Mental Health Services, Journal of Feminist Family Therapy, 25:1, 17-40

To link to this article: http://dx.doi.org/10.1080/08952833.2013.755081

PLEASE SCROLL DOWN FOR ARTICLE

Full terms and conditions of use: http://www.tandfonline.com/page/terms-and-conditions

This article may be used for research, teaching, and private study purposes. Any substantial or systematic reproduction, redistribution, reselling, loan, sub-licensing, systematic supply, or distribution in any form to anyone is expressly forbidden.

The publisher does not give any warranty express or implied or make any representation that the contents will be complete or accurate or up to date. The accuracy of any instructions, formulae, and drug doses should be independently verified with primary sources. The publisher shall not be liable for any loss, actions, claims, proceedings, demand, or costs or damages whatsoever or howsoever caused arising directly or indirectly in connection with or arising out of the use of this material.

Journal of Feminist Family Therapy, 25:17–40, 2013
Copyright © Taylor & Francis Group, LLC
ISSN: 0895-2833 print/1540-4099 online
DOI: 10.1080/08952833.2013.755081

Routledge
Taylor & Francis Group

Seeking Support: Transgender Client Experiences with Mental Health Services

KRISTEN E. BENSON
Department of Human Development and Family Science, North Dakota State University, Fargo, North Dakota, USA

Downloaded by [North Dakota State University] at 13:54 27 February 2013

Mental health research and practice has traditionally maintained a view of transgender people through the narrow lens of gender identity disorder. Recently, broader understandings of gender have influenced affirmative therapy with transgender clients. The purpose of the present research is to critically review historical views of transgender clients and to highlight experiences of transgender clients in therapy. Feminist phenomenology informed in-depth interviews with seven people who self-identify as transgender. Four themes emerged: the purposes transgender clients sought therapy, problems in practice, therapist reputation, and transgender affirmative therapy. Transgender affirmative practice and training implications are discussed.

KEYWORDS feminist research, feminist theory, gender identity, gender identity disorder, LGBT affirmative therapy, mental health, phenomenology, qualitative research, queer, Standards of Care, therapy, transgender

A QUALITATIVE EXPLORATION OF TRANSGENDER PERSPECTIVES OF THERAPY

Gender identity refers to a person's deeply held sense of their own gender, which is not established by the sex they were assigned at birth (Lev, 2004).

Received February 1, 2012; accepted May 4, 2012.
The author extends sincere gratitude to Fred Piercy, Ph.D., for his mentorship and guidance during this project.
Address correspondence to Kristen E. Benson, Department of Human Development and Family Science, North Dakota State University, P.O. Box 6050, Fargo, ND 58108-6050. E-mail: Kristen.Benson@ndsu.edu

Clinical training rarely includes information relevant to transgender clients, which results in practitioners who are not adequately prepared to work with this population (Carroll, Gilroy, & Ryan, 2002). The lack of transgender representation and exploration of issues concerning gender identity in clinical literature has been well documented (Lev, 2004), and research shows a prevalence of clinician ignorance and insensitivity to transgender issues (Shipherd, Green, & Abramovitz, 2010). Although visibility of transgender people is increasing and more clients who identify as transgender are seeking therapy services, there are limited resources available to clinicians, as well as significant gaps in the literature regarding transgender experiences with mental health. An increased focus of transgender well-being and relational health is called for in the couple and family therapy literature, yet largely remains absent (Coolhart & Torres Bernal, 2007).

Research on transgender people's emotional and mental health has historically focused on individual pathology and diagnosis. There has been a recent increase in the literature that addresses the experiences of transgender people from a non-pathologizing and non-stigmatizing stance (Lombardi, 2009); however, these writings are frequently theoretical or written from the perspective of an experienced clinician (i.e., Embaye, 2006; Emerson & Rosenfeld, 1996; Israel, 2005; Piper & Mannino, 2008; Saegar, 2006), not based on data from a research study. While clinical experiences and theoretical models are valuable and have helped to transform practice, there continues to be a gap with regard to mental health research with transgender populations in the professional literature. Lesbian, gay, bisexual, and transgender (LGBT) people are increasingly addressed; however, clinical literature tends to explore sexual orientation and fails to fully include emphasis on gender identity.

Much of the clinical research that does exist concentrates on the mental health of transgender children or diagnosis. Studies on parent-child interactions of children who appear to not conform to traditional gender roles (Grossman, D'Augelli, Howell, & Hubbard, 2005; Grossman, D'Augelli, & Salter, 2006) tend to focus on etiology by seeking to understand the causes of transgenderism, often by blaming parents (Emerson & Rosenfeld, 1996). Mental health research has traditionally focused on physicians treating gender identity disorder (GID) by considering options for patients undergoing sexual reassignment surgery, endocrinologists administering hormones, and psychologists, psychiatrists, and counselors treating individuals with gender dysphoria and other gender identity diagnoses as outlined in the *Diagnostic and Statistical Manual of Mental Disorders-IV-TR* (*DSM-IV-TR*). Much of the literature maintains focus on the Standards of Care for Gender Identity Disorders (www.wpath.org) and the diagnosis of GID (American Psychiatric Association, 2000), but does not address transgender people in a manner that indicates health and well-being.

Well-intended researchers and clinicians who seek to affirm transgender people often unintentionally reinforce a socially sanctioned two-gender

Downloaded by [North Dakota State University] at 13:54 27 February 2013

system. Feminist critiques have shaped mental health practices, yet they too have traditionally upheld an essentialist view of gender in which efforts to address gender inequities often rely on binary gender categories. Society mediates and places value on bodies so feminists see gender as a social issue because it is society that defines gender roles and norms and the difference between male and female (Hare-Mustin & Marecek, 1988; Lorber, 1994). Although sex and gender have distinctly different meanings, it is common to hear these terms used interchangeably in both popular culture and scholarly writing (Kessler & McKenna, 1978). Sex is a social classification of people as female or male that corresponds to perceptions of biological anatomy and physiology (Lev, 2004; Kessler & McKenna, 1978). Kessler and McKenna (1978) refer to the gender/sex distinction as a cultural/biological distinction. Gender refers more broadly to the experiences and socially-constructed understanding of people as feminine or masculine. However, given the complexity of gender as "culturally mutable," a binary lens of sexuality is limited and simplistic (Sedgwick, 1990). Butler (2004) stated that gender has no essence, rather gender is reiterated in everyday practices. She explained that gender norms are guided by ideological frames that go on to reinforce behavioral patterns to shape the reenactment of those norms (Butler, 2004). While people hold the belief that gender norms are inherent, they are copying expectations of their perceptions of gender. These perceived realities of gender are continually reinforced through everyday activities such as the way a person walks or dresses.

Both sexual orientation and gender identity are based on a socially constructed two-gender system, reinforcing the binary ideas that only the categories male and female exist. LGBT populations face similar discrimination in terms of legal issues and social stigmas around socially-sanctioned appropriate gender behavior. Sexual orientation and gender identity both rely on sex/gender categories; they are interconnected yet different in that sexual orientation is determined by who a person is attracted to (i.e., a man who is attracted to another man), while gender identity is based on a person's belief about who they are (i.e., a biological male who identifies as a woman). Unfortunately, transphobic attitudes and beliefs are maintained by lesbian, gay, and bisexual people who uphold traditional beliefs about biological sex and social gender (Lombardi, 2009).

Downloaded by [North Dakota State University] at 13:54 27 February 2013

GENDER DIAGNOSIS: CHANGING FOREFRONTS

GID was included in the *Diagnostic and Statistical Manual of Mental Disorders* shortly after gay rights advocates successfully removed homosexuality, a proclamation that same-sex oriented people are not mentally disordered (Hausman, 1995). Mental health diagnosis of GID is greatly debated, and many challenge the purpose of labeling people who express sexual diversity (Lev, 2005), as it reinforces the conflation of sex and gender.

Diagnosis can be useful in helping professionals and consumers of mental health treatment to understand emotional and mental disturbances; however, these same criteria have been developed and used to stigmatize people who are socially considered to be deviant or live outside norms of acceptability (Lev, 2004).

The narrow diagnostic criteria for GID generally exist for the purpose of referring a client for medical treatment which included prescriptions for hormones or surgery (Hanssmann, Morrison, & Russian, 2008). Lev (2005) questioned the ethics of using psychiatric diagnosis to legitimize access to medical treatment for transgender people because to be transgender does not mean a person has a psychological disease requiring treatment. Diagnosing GID is problematic due to lack of clarification between gender dysphoria and gender role nonconformity (Bockting & Ehrbar, 2005). The current GID diagnostic criterion confuses gender dysphoria, or distress due to assigned sex, with gender role nonconformity, or the characteristics related to feminine or masculine behavior. The *DSM-IV-TR* (2000) states, "In boys, cross gender identification is manifested by a marked preoccupation with traditionally feminine activities . . . Girls with gender identity disorder display intense negative reactions to parental expectation or attempts to have them wear dresses or other feminine attire" (p. 576). Feminine or masculine clothing and behavior are culturally determined and constantly change, which highlights the social construction of a category used to diagnose. Bockting and Ehrbar (2005) reviewed critiques of the GID diagnosis and found that children could be diagnosed with GID yet not exhibit gender dysphoria, or distress, due to their gender identity. This assumes that there are normal and abnormal ways to express gender, rather than recognize the "full range of behaviors and experiences engaged in by 'normal' males and females in contemporary society" (Lev, 2005, p. 51). Bockting (2009) argued that GID stigmatizes a person's identity, as compared to a less intrinsic mental disorder, and those stigmatizing effects have not been adequately studied.

According to the American Psychiatric Association (2010), the *DSM-V* is projected to be published in 2013. In addition to the task force developed to oversee the development of *DSM-V*, a Sexual and Gender Identity Disorders Work Group has been appointed to review the research, literature, strengths, and problems related to diagnostic categories of GID in the *DSM -IV*. As a result, the Sexual and Gender Identity Disorders Work Group has recommended that GID be renamed Gender Dysphoria. They also recommend diagnostic criteria for Gender Dysphoria center on incongruence between gender and secondary sex characteristics, rather than gender identity reflected in the current *DSM-IV*. Changes to diagnostic criteria in the *DSM* have the potential to drastically impact transgender people's access to medical treatment and the way in which the Standards of Care are carried out. The ongoing revisions of gender diagnosis in the *DSM*, as well as who has agency to create those changes, exemplifies the socially constructed nature

Downloaded by [North Dakota State University] at 13:54 27 February 2013

of how gender is defined and decided. For example, a person who meets the criteria for GID today may not meet the criteria for Gender Dysphoria two years from now, and may not meet diagnostic criteria at all.

The World Professional Association for Transgender Health (WPATH) recently released a revised version of the *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* (2011), which is considered the primary guideline for working with transgender people in health settings. The *Standards of Care* (*SOC*) is an ethically defined series of principles and best practice standards for treating transgender and transsexual patients in regards to well-being, physical, and mental health. The Harry Benjamin International Gender Dysphoria Association first issued standards of care for treating transsexualism in 1979. It included both ethical standards on the part of medical practitioners and mental health providers, as well as the patients who, until recently, were required to live as the "opposite sex" for at least one year prior to surgery. This perspective historically encouraged professionals working with transgender people to focus on the body; the standards of care determined a person's candidacy for undergoing bodily alterations based on their psychological well-being. The goal of such treatment was to determine if a person was ready for gender transition by use of the medical establishment based on both their psychological well-being and also their psychiatric diagnosis. Essentially, professionals invested in bodily representation of gender determine patients' sex rather than acknowledging other myriad issues that transgender individuals might seek therapy to address. The positioning of mental health professionals has led to some skepticism among transgender clients.

Transgender clients have experienced some distrust regarding mental health clinicians based on their problematic position as gatekeepers to gender transition (Lev, 2004). Since the goal of therapy is to obtain a letter from the therapist to approve moving forward for medical treatment, there exists a concern that clients may not be forthcoming about actual problems they face because they are focused on presenting a healthy sense of being to the therapist (Lev, 2004). Transgender people who seek physical transition may approach mental health practitioners with the intent of gaining access to treatments such as sexual reassignment surgery (SRS), subcutaneous mastectomy (breast removal), breast augmentation, hormone therapy, electrolysis, and facial reconstruction. The therapist served in a capacity to protect the client from undergoing medical treatment unprepared and to protect surgeons from litigation should the client not be prepared for the results of surgery (Lev, 2004). As a result, therapy has not been viewed as a place to address life challenges, and instead served as an access point to medical intervention, which largely excluded non-operative people from mental health treatment altogether.

SOC are revised to address the changing needs and growing body of relevant information (Bullough, Bullough, & Elias, 1997), and have been

Downloaded by [North Dakota State University] at 13:54 27 February 2013

published seven times with revisions in 1980, 1981, 1990, 1998, 2001, and most recently 2011 (www.wpath.org). Prior to the seventh version, a person had to be diagnosed with GID in order to take steps to undergo hormone treatments or SRS. The most significant changes in the newest version of the *SOC* include decreased focus on diagnosis, increased recognition of interpersonal relationships, and an emphasis on flexibility of use. More specifically, the *SOC* state that the guidelines "are intended to be flexible in order to meet the diverse health care needs of transsexual, transgender, and gender nonconforming people" (p. 2). As the *SOC* have become more flexible, clinical practice has shifted from a primary focus on diagnosis and transition to more inclusive quality of life issues. Literature, professional conference presentations, and some graduate programs have begun to embrace affirmative approaches to working with transgender clients.

Downloaded by [North Dakota State University] at 13:54 27 February 2013

NON-PATHOLOGIZING, AFFIRMATIVE PRACTICE

Most mental health professionals have never received training on sex and gender identity (Lev, 2004), and have never challenged assumptions about sex and gender. This lack of understanding regarding the complexity of gender renders well-intentioned clinicians ill-equipped to effectively serve the transgender community. Many clinicians who work with transgender clients have never received formal training on gender identity outside of a diagnostic framework. More recently, introductory trainings on interacting with transgender people have been made available for health care staff and providers in an effort to reduce barriers to services (Hanssmann et al., 2008). These types of training are rarely integrated into health professional training curriculums (Hanssmann et al., 2008), and even less so for mental health practitioners. Lack of formalized training expectations and limited information reinforce the notion that knowledge about LGBT health is optional (Hanssmann et al., 2008).

The inclusion of gender theory and information about gender identity in clinical training is critical in preparing therapists to work with diverse clientele. Further, information about transgender people as a population is not enough. Training must address complex understandings of sex and gender as well as larger systems of oppression, and be direct by using language that clearly demonstrates transgender inclusion. For example, the Council on Social Work Education (CSWE): Educational Policy and Accreditation Standards states that diversity considered the intersections of "age, class, color, culture, disability, ethnicity, gender, gender identity and expression, immigration status, political ideology, race, religion, sex, and sexual orientation" (2008, p. 5). The CSWE further exemplified inclusive practice by stating that social workers

> recognize the extent to which a culture's structures and values may oppress, marginalize, alienate, or create or enhance privilege and power; gain sufficient self-awareness to eliminate the influence of personal biases and values in working with diverse groups; recognize and communicate their understanding of the importance of difference in shaping life experiences; and view themselves as learners and engage those with whom they work as informants. (p. 5)

Since diversity is a core element of mental health training, including gender identity in training programs will contribute to better informed and aware therapists. Murphy, Park, and Lonsdale (2006) found that a course on diversity issues significantly increased students' multicultural knowledge, skills, and awareness. Godfrey, Haddock, Fisher, and Lund (2006) recommended that in order to prepare trainees to work with GLB clients, therapist trainers should focus on self-of-therapist issues, classroom learning, and supervision, which can apply to work with transgender clients.

Rock, Carlson, and McGeorge (2009) looked at beliefs, competency, and level of affirmative training couple and family therapy students received for working with gay and lesbian clients. They defined affirmative therapy as "an approach to therapy that embraces a positive view of LGB identities and relationships and addresses the negative influences that homophobia and heterosexism have on the lives of LGB clients" (p. 10). These ideas are applied with transgender populations in clinical settings where therapists recognize the impact that transphobia, or the irrational fear or hatred of people who transgress dominant social gender categories (Association of Lesbian, Gay, Bisexual, and Transgender Issues in Counseling [ALGBTIC], 2009), has on clients. In this article, affirmative therapy refers to a therapeutic approach that adopts a positive view of transgender clients by respecting their self-defined identities and addresses the impact of a normative gender society on their lives. Affirmative therapists possess an understanding of the stigmas that transgender clients live with and accept the person as they define themselves in terms of their gender and sex. They grasp the knowledge and skills needed to work with these clients in a manner that does not legitimize bias against them and assist them in exploring complexities in their relationships. In the context of families and relationships, the affirmative therapist that works with loved ones affirms struggles but does not take the position to support self-destructive behaviors.

Affirmative practice requires that clinicians understand terminology and concepts regarding gender identity. Clinicians' beliefs about sex and gender are frequently conflated, leading to confusion regarding the distinction between sex and gender. Well-informed affirmative therapists are not only familiar with common terminology, they are aware of how societal assumptions about gender influence the experiences of clients. They understand that not all transgender people identify within the two-gender binary, and may identify as gender queer or use other language to identify their gender.

Downloaded by [North Dakota State University] at 13:54 27 February 2013

Transman is a person who is biologically female, or assigned female at birth, and identifies as male. Transwoman refers to a person who is born biologically male, or assigned male at birth, and identifies as female. Cisgender refers to people whose gender identity and the gender they were assigned at birth based on their bodies match (Schilt & Westbrook, 2009). Transition is known as the process of a transgender person undergoing physical and/or legal changes to live as their desired sex category. This may include hormone therapy, SRS, dressing full time in a manner typically associated with a particular gender, legal name change, etc. Gender terms do not necessarily mirror a person's perception of him/herself. The terminology offered in this article is intended to introduce clinicians to commonly used terminology, yet not assume that all terms fit universally for all people.

Clinicians who understand experiences and issues transgender people face can provide transgender clients with more effective treatment (Grossman et al., 2005). Tolerance of LGBT clients is not enough; rather, therapists should be aware of their privilege and reflective of how they may be seen as representing majority culture which has been the source of oppression for transgender clients. Training programs have failed to include basic terminology or address transgender social, health, and relational issues. The ALGBTIC (2009) has developed a set of competencies for working with transgender clients and relationships that addressed eight primary areas: human growth and development, social and cultural foundations, helping relationships, group work, professional orientation, career and lifestyle development competencies, appraisal, and research.

The purpose of this study was to investigate transgender people's experiences and understanding of how mental health clinicians understand and support them. This study aims to give voice to self-identified transgender people and provide therapists an opportunity to learn from the experiences of this marginalized population. The research questions that guided this inquiry were: What is your experience of mental health services? Specifically, have you ever been to see a counselor, therapist, psychologist, or psychiatrist? If so, what was this experience like?

Downloaded by [North Dakota State University] at 13:54 27 February 2013

METHODS

These data were part of a larger study examining gender identity and relationships (Benson, forthcoming). A feminist-informed approach to phenomenology guided this study in an effort to understand and make meaning of transgender people's experiences of therapy. The purpose of phenomenological research is to describe and understand the lives and comprehensive experiences of the participants (Dahl & Boss, 2005) in the context of a particular situation (Moustakas, 1994). All the participants have a phenomenon in common, which contributes to the development of a description of the

"essence of the experience for all the individuals" (Creswell, 2007, p. 58); in this case, transgender people who have experience with mental health services.

Feminist scholarship addresses gender-based stereotypes and biases, and fosters empowerment for marginalized groups (Brooks & Hesse-Biber, 2007). Much like Oswald, Blume, Berkowitz, and Kuvalanka (2009) described, this study situates queer theory within feminist family scholarship. Both queer theory and feminist theory explore how gender and sexuality are performed in a changing social context (Oswald et al., 2009). The intent of this study is inherently feminist with the intention to promote social justice and foster social change (Brooks & Hesse-Biber, 2007) by identifying and recognizing transgender people's experiences with mental health professionals to inform and improve clinical practice.

Downloaded by [North Dakota State University] at 13:54 27 February 2013

Participants

Purposive and snowball sampling was used to recruit seven transgender participants through e-mail lists and support group participants. The sample included one Latino(a) and six European Americans. Participants ranged in age from 24 to 57 years old ($M = 39.85$, $SD = 14.62$). Three participants reported they are biologically female and identified female-to-male, three participants reported they are biologically male and identified male-to-female, and one participant reported he was biologically male and identified male-to-female cross dresser. Six participants are in partnered relationships including three who are legally married, and one is divorced. Female-identified participants were older, ranging from 45 to 57, had been married at least once with biological children, earned a graduate or professional degree, maintained a higher socio-economic status, and explored their gender identity later in life. Male-identified participants were younger college students, ranging from 24 to 26, with lower socio-economic status. While participants self-selected to participate (Benson, forthcoming), Maguen, Shipherd, Harris and Welch's (2007) study may explain the phenomenon that recently transgender people are likely to disclose their gender identity at younger ages.

Procedures

Interviews were conducted at locations convenient to participants, which included offices and participants' homes. Prior to beginning the interview, I explained my intention to be an ally. My own experiences as a member of the LGBT community have opened my eyes to the prejudice and hardships that exist for LGBT people, which has enhanced my desire to research and work clinically with this population. As a feminist researcher, I believed in remaining transparent as I approached this research. Given the enormous degree of prejudice that transgender people face, I made even further efforts

to be clear about my intentions. I disclosed my professional and personal motivation for collecting data that could lead to transgender affirmative training and therapy practices. This minimal amount of self-disclosure seemed to put participants immediately at ease. I explained the purpose of the study and invited participants to ask questions before we began. I assured them that I hoped to better support them and other transgender people by hearing their stories and attempting to understand their experiences. Participants then read and signed informed consent documents and completed a demographic questionnaire. Once participants indicated they were ready to begin the interview, I turned on the digital audio recorder. I used a semi-structured interview guide which included open-ended questions. The length of interviews ranged from 45 minutes to 3 hours.

Downloaded by [North Dakota State University] at 13:54 27 February 2013

Data Analysis

Inductive thematic analysis involved coding and identifying patterns, themes, and sub themes in the data (Braun & Clarke, 2006). Braun and Clarke's (2006) six phases of thematic analysis guided data analysis and included (1) familiarizing myself with the data as the sole interviewer and reading through transcripts several times, (2) generating initial codes within the data by highlighting and making notes in the margins, (3) continued searching for themes by organizing categories, (4) constantly reviewing themes by looking within each transcript and across the data to identify repeated patterns, (5) defining and naming themes by combining codes to create larger themes and subthemes before moving into the final phase, and (6) creating the scholarly report. Themes reflect detailed experiences and meanings described by the participants.

Trustworthiness parallels criteria for rigorous research methods, ensuring reliability and validity of the data (Lincoln & Guba, 1986). As I engaged in face-to-face interview conversations with participants, read, coded, and reviewed field notes, and discussed the data with colleagues, I formed a comprehensive relationship and understanding of it. Participants were sent copies of transcripts to review for accuracy and offer feedback. I engaged in peer debriefing with a transgender graduate student and social science colleague in a discipline outside my academic department. After interviews and member checks were completed, I reviewed and revised earlier literature reviews based on the research findings to further understand emergent themes.

FINDINGS

The participants in this study all self-identified as transgender and had some experience as a client/consumer of mental health services. The interviews

with the seven transgender participants in this study uncovered a total of four themes and two subthemes: the purposes transgender clients sought therapy which included subthemes quality of life and gender identity, problems in current practice, therapist reputation, and transgender affirmative therapy. Direct quotes from the interviews provide depth and support for the described themes.

Purposes for Seeking Mental Health Services

Participants described delineating between purposes for seeking mental health services to address quality of life issues and gender identity. While all participants had been involved with mental health services to some degree, each person experienced a unique reason for seeking therapy. Several challenged the assumption that transgender people seek mental health services because their gender identity is problematic; instead they experienced many "normal" life challenges that cisgender, or people who are not transgender, face in addition to dealing with stigma.

Quality of life. Seeking mental health services for quality of life refers to well-being, relationship satisfaction, and emotional health. Therapists may assume that transgender clients attend therapy to address their gender identity, which is reinforced in the diagnostic focused literature; however, participants described multiple reasons they initially sought mental health treatment. Prejudice and stigma held against transgender people contributed to emotional hardships, not solely their gender identity. The emotional weight of experiencing and fearing transphobia contributed to seeking out therapy. One transwoman reflected her thoughts this way:

> Transgendered individuals are going to come to a therapist and most of their issues have nothing to do, specifically, with being transgendered. It has to do because they've had to hide, they've had to lie, and they've felt all of this guilt and shame, unfortunately usually for years!

Four participants had pursued either family or couple therapy to improve relational issues with loved ones. One transman saw his Catholic priest for premarital therapy, and a single parent transwoman brought her two young sons to family therapy to help them through their parents' divorce. A transwoman who had been married for over thirty years remarked

> I've never been to a counselor for gender issues . . . I went to a psychologist for my anger issues. And [my wife] and I together for our marriage because of the anger issues.

Several participants described their struggles with mental health diagnosis such as depression and anxiety that led them to seek therapy. While

Downloaded by [North Dakota State University] at 13:54 27 February 2013

gender identity was not considered to be the presenting problem at the time they sought mental health services, some participants retrospectively recognized that their gender identity was related to the mental health or emotional issues that they faced in the past. A 26-year-old male-identified participant reflected on his mental health history by stating

> My second year of college is really when I started getting treatment for depression. I had a lot of really bad social anxiety in high school, and probably before that, I never got any treatment for it. I say that almost any anxiety has gone down a lot since I'm passing as male and just feel more comfortable with myself . . . I feel like most of my depression is because of the anxiety and just not knowing [my gender] in the past.

Participants discussed the importance of acknowledging their gender identity with a therapist in order to discuss other quality of life issues. One 56-year-old female-identified participant stated that life circumstances related to depression led her to therapy, yet her ability to discuss her gender identity was important to her. She stated

> I was very lucky because the person I went to knows about transgendered issues . . . I didn't go to her because of transgender issues; I went to her because of depression. I was just overwhelmed . . . and I knew that I couldn't talk to a counselor about my depression and so forth if they weren't aware about [my female identity] being a major part of my life.

Gender identity. A specific focus on gender identity and the desire to pursue transition led some participants to pursue mental health services. All of the transmen who participated in this study were in the process or had completed name and gender changes on legal documents, which required support of medical or mental health professionals. They described the requirement to obtain a therapist letter of support to move forward with medical treatments and legal name changes when seeking gender transition. A transman expressed satisfaction with his mental health team. After received support from his therapist to move forward with medical transition, he described an experience with a psychiatrist:

> I just recently went to a psychiatrist . . . about my hysterectomy, and they wanted to make sure that was right for me, and we both agreed that it was right for me to get it done and that I'm ready.

Therapy for gender identity was not always sought out due to mental health need. The requirements to meet the *SOC* were frustrating to some, as explained by this transman:

Downloaded by [North Dakota State University] at 13:54 27 February 2013

> I think it's annoying that I have to go and convince somebody that I'm trans and have them write a letter.

Mental health professionals provided legitimacy of gender identity for transgender people. Participants shared stories about self-exploration of their gender identity as well as the response of family members and partners. A 46-year-old female-identified participant shared her concerns when she was going through a divorce after disclosing her gender identity to her wife. She stated her desire to better understand gender identity and her hope that a legitimate professional opinion would be helpful to her in court:

> I [went to therapy] from the beginning of our separation five years ago, because the reason for our separation was me being transgender . . . my attorney recommended from the point of view that it would bolster our case in court to be able to understand and explain this [gender identity] to a judge, rationally in that sense, but he also thought it would personally do me a lot of good so that I can understand and explain this for myself.

Downloaded by [North Dakota State University] at 13:54 27 February 2013

Problems in Practice

The second theme that emerged regarding experiences with mental health was the belief that therapists are not well-informed about transgender issues. Participants discussed the need for transgender-informed therapists and their beliefs that most therapists are not accurately educated or rely on clients to teach them about the need of transgender people. They stated concerns about paying for therapy, yet feeling as though they had to spend time educating their therapist. While they sought to be listened to and supported by therapists, the following quote highlights how misunderstood one participant felt with multiple previous therapists:

> I just had therapists who have crazy, off-the-wall ideas and just not really understood who I was or really taken the time to understand. They just want to apply a bunch of stuff to me . . . I've just had experiences where [therapists] just don't seem to really care . . . they just seem preoccupied and they're not even trying to understand me.

They shared concerns that clinicians do not receive adequate training on gender identity, and that mental health professionals do not know the difference between sexual orientation and gender identity. A transman, who happened to be enrolled as a student in a psychology graduate program, spoke about his concerns related to clinical training. He described his views on the minimal information mental health professionals receive on supporting transgender people:

> Most people probably are familiar with the term transgender, but maybe that's it. I don't think I've had any formal training just going through [clinical] programs . . . I don't think most [therapists] know. Most therapists—Master's degree, PhD level—they've had . . . one diversity class on GLBT issues. One class out of the huge diversity training. One class. And it was probably mostly about gay lifestyle.

The notion that many clinicians learn about gender identity from their transgender clients was a common belief. Transgender participants expressed doubt when asked about mental health professionals' ability to understand and help them. For example, one transwoman responded

> I think most of them listen to the transgendered clients so that they can learn something about the issue. I think for the most part they don't know beans about what makes a transgendered person tick.

Concerns about being stereotyped or misunderstood by uneducated therapists and counselors surfaced. The following transwoman also stated her concern that most therapists in her community do not receive sufficient training prior to working with transgender clients, and do not realize the diverse of experiences of transgender people. She expressed her thoughts on limited training and what she considered an ignorant use of the *SOC*:

> Most of them don't have any idea what to do. There are two [counselors] that I know of in town that do probably. But again, most of them scurry to do their homework after they hear the first session. And I know those are guidelines and they have, you have to start somewhere so they're helpful, a starting place. And then they get out the Harry Benjamin Standards and they try and fit everybody into those standards which I don't think are very appropriate sometimes. Most counselors that I am familiar with end up trying to fit a person into a profile rather than develop the profile around who the unique person is. That's why I'm a little leery of being put in somebody else's box.

Finances were a significant concern for the younger participants in this study, who were all transmen and enrolled in college. Many insurance health insurance policies do not cover treatment associated with gender transition, and numerous young people are under or uninsured. Younger participants explained their financial struggles that created more difficulty locating a clinician who works with transgender clients. One 24-year-old transman explained some of the barriers and frustrations he felt:

> I asked people from [transgender support group] who they were going to see. Money was definitely an issue. I can't afford to pay a hundred dollars a session. And so my friend told me, 'yeah this guy sees me for

Downloaded by [North Dakota State University] at 13:54 27 February 2013

> twenty-five bucks for an hour every week,' and I [thought], I can do that. 'And he has experience with F-to-Ms' so I was like, cool.

Therapist Reputation

All of the participants in this study were connected to a transgender advocacy group in some fashion, which proved to be beneficial in located transgender-friendly clinicians. While they expressed doubts about most mental health professionals, they sought therapists and counselors who were aware of gender identity and had experience working with transgender clients. Word-of-mouth was overwhelming the primary mode of locating transgender affirmative therapists. One 24-year-old male-identified participant looked to friends in the transgender community for referrals to transgender-friendly therapists:

> The [therapists] that I went to were really good; they were well-informed. I also hear from other friends that its word-of-mouth, like "go to this person, they're good," or "I've been to them." It's more of finding out and doing research of other transgendered people of who they went to and finding out who they recommend. It is how I found mine.

Therapists who were visible supporters of transgender people and were actively engaged in transgender advocacy efforts developed positive reputations. A transwoman described her knowing of the therapist she would eventually work with long term:

> I had met her before. She had spoken at meetings. I think I met her at a [support group] meeting and she knew [my friend] socially.

Similarly, another participant stated

> I would only really go to a therapist if I knew they were GLBT-friendly or specializing in it now. So I could only imagine that a regular therapist would know nothing about it.

Transgender Affirmative Therapy

The majority of participants discussed the fourth theme, transgender affirmative therapy. They talked about the ability to "jump into" the issues they wanted to talk about in therapy, rather than having to explain or educated therapists about gender identity. Sensitivity to life circumstances and affirmation of identity were essential for participants to feel their therapist could be helpful to them. They were not interested in educating their therapists about what it means to be transgender and preferred clinicians who had

Downloaded by [North Dakota State University] at 13:54 27 February 2013

either received training and/or experience working with transgender clients. Several participants sought out referrals from other people in the transgender community for therapists who were well-informed and had developed a reputation for working with transgender clients. For example, one participant described being able to "hit the ground running" with her therapist who "knew about what makes transgender people tick" and went on to say

> The ones that I worked with knew what they were talking about, and they've had other clients that were transgendered before.

Mental health clinicians who describe their practice as transgender-friendly or worked at agencies that clearly stated they welcome LGBT clients signified safety to participants. Therapists who were willing to identify themselves as supportive of the LGBT community indicated that they were aware that transgender clients look for clear indications that a clinician has the knowledge and sensitivity to work with them. A participant described his experience going to a therapist who had received affirmative training:

> Well, I have to give [my current therapist] a lot of credit. When I came in to work with her, obviously she was specializing in GLBT therapy. But she said that she didn't want to waste a lot of time having me describe to her what being transgender is all about. She said that she was willing to like go and research it herself. And just talk about your experiences and what's going on in your life, and if you're talking about something that's related to transgender that you think that I should just know, or you wish that somebody would just know, just let me know, and I'll go research it . . . So I didn't have to put all my issues on hold, and have four days of explaining transgender and get into everything. I thought that was really cool, right off the bat.

Affirmation of identity was recognized as an essential component of affirmative therapy. Therapy was experienced as helpful when mental health professionals validated and celebrated participants' circumstances. One transman described his experience in couples therapy with a clinician who did not focus on gender categories:

> I was like, okay so I identify as transgender or transsexual male and I'm on hormones and this is [my cisgender lesbian-identified partner]. He's like, 'that is so wonderful that you can be who you are.' And he's really like that when he talks. He's like, 'wow, I just think the world of you two. You are amazing!' All this validation and affirming was so powerful. That's what is needed, to go in and just to feel so comfortable with another person that you've never met before, and it wasn't like too much because there can be too much. But it was just the right amount of affirmation. He was great.

Downloaded by [North Dakota State University] at 13:54 27 February 2013

DISCUSSION

The purpose of this study was to explore the experiences of transgender people experiences with mental health clinicians. The following discussion will focus on contributions of this research, clinical and training implications, and the limitations of the study.

Diagnosing Gender?

Previous mental health lens of "treating" transgender people centered on a diagnosis of GID and the clinician's role in determining clients' readiness for gender transition procedures (Lev, 2004). The transgender people who participated in this study described their primary reasons for seeking professional mental health support as improving quality of life and addressing gender as required to move forward with gender transition. GID diagnosis suggests that there only exist two genders in a binary system; however, multiple ways of expressing and performing gender have been documented in the literature (Israel, 2005; Lev, 2010).

Literature suggests that GID is derived more from a conflict between the individual and society rather than an individual's mental health (Bartlett, Vasey, & Bukowski, 2000). None of the participants viewed their gender identity as problematic; rather, they expressed a desire to see therapists who affirm and support them as the gender they identify. For those who were seeking gender transition, the approval of mental health providers meant access to medical care that they saw necessary to change their bodies to lead the kind of life they wanted to live as indicated in the *SOC* (www.wpath.org). Participants discussed varying degrees of transition, and mental health care helped normalize this experience and provide access to it. Those participants who sought gender transition wanted to work with a therapist who would support their decisions, which also highlights the importance of familiarity with the *SOC* as they are updated.

It is important that clinicians be aware of the history of gender bias in the *DSM* (ALGBTIC, 2009). The focus on pathology has failed to address the impact of transphobia in the lives of transgender people. Transphobia and mental health has under researched, under addressed, and under acknowledged (Lev, 2004). Transphobia can cause access to social resources to be compromised when transgender people transition (Lombardi, 2009). A recent report of the by the National Center for Transgender Equality and National Gay and Lesbian Task Force revealed that 63% of transgender people experience serious acts of discrimination that significantly impacts their quality of life (Grant, Mottet, Tanis, Harrison, Herman, & Keisling, 2011).

Participants' beliefs that therapists have little knowledge or training about transgender issues are supported in the literature (Emerson & Rosenfield, 1996; Lev, 2004; Raj, 2002). All the participants expressed a belief

Downloaded by [North Dakota State University] at 13:54 27 February 2013

that mental health services can be and are helpful given the provider is informed about transgender issues. Participants believed that therapists are not well-informed about transgender issues, yet the participants' value of those therapists who are informed is consistent with the literature which indicates a shift away from pathology (Carroll et al., 2002; Raj, 2002, 2008).

The findings of this study are similar to Rachlin's (2002) survey research which found that transgender clients commonly sought out therapy for personal growth issues and later sought out a therapist who had experience with transgender issues. There was a clear difference in what it meant to seek mental health services for issues related to gender identity as compared to other life circumstances such as depression, anxiety, and relationships. The ALGBTIC also support the finding that a client's primary reason for seeking therapy may not be related to gender identity (2009).

Affirmative Practice

Participants looked for mental health professionals who were understanding, did not judge them, affirmed their gender, and cared about their unique experiences. They remembered moments they felt accepted by providers who validated their gender identity. When mental health professionals responded in ways that felt accepting, participants felt affirmed. Clinical practice should be dynamic and tailored to each client (Bockting, Knudson, & Goldberg, 2006), free of therapists' assumptions that clients are attending therapy to focus on gender identity. Therapists should ask themselves the following questions: How can I be curious and open to learning about clients' unique experiences related to their gender identity without placing them in a position to educate me about the phenomenon of transgenderism? How do I create and promote clinical practice that is inclusive, affirming, and supportive for clients with varying gender identities and expressions?

In an effort to combat discriminatory practices, therapists can be intentional in providing a safe and affirmative space where transgender clients are free to explore the complexity of their experiences without expectation of an identity development stage or psychiatric diagnosis. Sensitivity and inclusion can be demonstrated by taking measures to ensure that clients know their gender identity is validated. Bockting et al. (2006) suggested that clinicians demonstrate awareness of transgender concerns by keeping brochures, books, and posters visible, as well as ensuring that intake forms are transgender inclusive For example, clinical paperwork can include clients' legal names as well as names that clients prefer and offer the option to fill in gender rather than check either the box for male or female. Intake paperwork can inquire about preferred names and pronouns to be used during therapy. Options that include partnership should be included when asking about relational status, rather than marital status. Therapists should

Downloaded by [North Dakota State University] at 13:54 27 February 2013

use gender-inclusive language that does not make assumptions about how a client identifies or who the client is in relationship with.

Participants reported that they located affirmative therapists through word-of-mouth from transgender friends, which is supported in the limited clinical research with transgender participants. For example, Bess and Stabb (2009) found that friends' referrals and LGBT community visibility helped transgender participants find their therapist. Engaging in outreach activities that involve transgender people, attending transgender-related community events, and getting involved in transgender advocacy efforts are substantial opportunities to confront personal bias and demonstrate support. Therapists must be willing to increase their awareness of gender bias and prejudices they hold that may impede work with transgender clients and their loved ones. Transphobia can manifest in obvious discrimination causing therapists to refuse to work with transgender clients. It can also lead to subtle ways in which transgender people are treated, such as the assumption that transgender people should not work with children (this is a comment from a former student in a class I taught). The more competent a therapist is regarding gender identity issues, the more likely barriers are reduced for transgender clients (Shipherd, Green, & Abramovitz, 2010).

Affirmative Training

The findings showed that transgender people have little faith that the majority of mental health practitioners have adequate ability to work with transgender clients, which is supported by the lack of training and skills documented in the literature (Lev, 2004; Raj, 2002). Effective training should include skills and experience, as well as sensitivity and awareness (Goldberg, 2006). There are a number of suggestions for transgender affirmative training which include incorporating curriculum about transgender people into clinical training and supervision, and increasing therapists' awareness of transphobia and heterosexism.

To some extent, students may experience a greater sense of competency working with transgender clients in an affirmative manner as they become more familiar with issues that transgender people face. Goldberg suggested a three-tier training system which moves from basic affirmative care to the ability to skillfully address societal stressors to an advanced level which indicates ability to assist with gender transition (2006). As students learn more about circumstances in transgender relationships in classroom learning, personally reflective, and practical settings, they increase their knowledge and ability to be empathetic.

Rostosky et al. (2004) emphasized the responsibility of clinicians to be educated "about the realities of institutional discrimination" (p. 54) and view problems in the context of societal prejudice and ignorance rather than pathology. Awareness of the ways that transgender clients experience

Downloaded by [North Dakota State University] at 13:54 27 February 2013

oppression and therapist's self-examination of their own gender-related privileges and assumptions should be addressed in training. For example, supervisors should encourage therapists to engage in reflection and self-awareness regarding their own biases and assumptions about gender identity and the influence those beliefs have on the therapeutic process. Personal interactions also help students to grasp the ability to be affirmative. Understanding and connection can be the result of opportunities to meet transgender people and interact through guest speakers in the classroom, social events that cater to the LGBT communities, and clinical work. Additionally, engagement in outreach activities that involve transgender people, attending transgender-related community events, and getting involved in transgender advocacy efforts are substantial opportunities to confront personal bias and work through misconceptions and transphobia.

Historically, mental health professionals have discriminated against transgender clients by being "insensitive, inattentive, uninformed, and inadequately trained and supervised" (ALGBTIC, 2009, p. 10). The findings of this study support previous research that claims textbook knowledge is not sufficient (Bess & Stabb, 2009), and experience working with transgender clients is needed. Clinical supervisors must commit to affirmative therapy and training practices in order to affirmatively teach the next generation of therapists. I am on the faculty at a Couple and Family Therapy training program that integrates readings on gender identity into coursework, regularly hosts transgender community members to speak with therapy students, and encourages students to participate in local LGBT pride events. As a result, the program training clinic has developed a reputation for providing low-cost transgender affirmative individual and relational therapy services. Additionally, this creates opportunities for therapists in training to receive live supervision while gaining experience seeing transgender clients in therapy.

LIMITATIONS

Transgender terminology was used in recruitment of participants. Demographic questionnaires asked if participants identify their gender as female, male, MFT, FTM, or other with a blank space for further explanation. This terminology reinforces the binary gender system, and also confuses sex terms (i.e., female, male) with what should be gender terms (i.e., woman, man). There was limited representation of people from differing racial, educational, and socio-economic backgrounds. The sample was predominantly white, educated, and employed. Participants with lower socio-economic status were enrolled in college. All participants were connected to a support group either in person or online. Suggestions for future research include recruiting a more diverse sample.

Downloaded by [North Dakota State University] at 13:54 27 February 2013

CONCLUSION

The present article gives voice to transgender people, a population that is understudied yet highly theorized (Eyre, De Guzman, Donovan, & Boissiere, 2004). Mental health professionals need transgender specific training to stand against a history of pathology and acquire the skills and sensitivity needed to best support transgender clients.

REFERENCES

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed.). (DSM-IV-TR). Washington, DC: Author.

American Psychiatric Association. (2010). *DSM-5 development*. Retrieved from http://www.dsm5.org

Association of Lesbian, Gay, Bisexual, and Transgender Issues in Counseling. (2009). *Competencies for counseling with transgender clients*. Alexandria, VA: Author.

Bartlett, N. H., Vasey, P. L., & Bukowski, W. M. (2000). Is gender identity disorder in children a mental disorder? *Sex Roles*, *43*(11/12), 783–784. doi:10.1023/A:1011004431889

Benson, K. E. (forthcoming). *A feminist phenomenological exploration of transgender disclosure in significant relationships*.

Bess, J. A., & Stabb, S. D. (2009). The experiences of transgendered persons in psychotherapy: Voices and recommendations. *Journal of Mental Health Counseling*, *31*(3), 264–282. Retrieved from http://www.amhca.org/news/journal.aspx

Bockting, W. O. (2009). Are gender identity disorders mental disorders? Recommendations for revision of the World Professional Association for Transgender Health's Standards of Care. *International Journal of Transgenderism*, *11*, 53–62. doi:10.1080/15532730902799987

Bockting, W. O., & Ehrbar, R. D. (2005). Commentary: Gender variance, dissonance, or identity disorder? *Journal of Psychology & Human Sexuality*, *17*, 125–134. doi:10.1300/J056v17n03_08

Bockting, W. O., Knudson, G., & Goldberg, J. M. (2006). Counseling and mental health care for transgender adults and loved ones. *International Journal of Transgenderism*, *9*(3/4), 35–82. doi:10.1300/J485v09n03_03

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*, 77–101. doi:10.1191/1478088706qp063oa

Brooks, A., & Hesse-Biber, S. N. (2007). An invitation to feminist research. In S. N. Hesse-Biber, & P. L. Leavy (Eds.), *Feminist research practice* (pp. 1–24). Thousand Oaks, CA: Sage Publications.

Bullough, B., Bullough, V. L., & Elias, J. (1997). *Gender blending*. Amherst, NY: Promtheus Books.

Butler, J. (2004). *Undoing gender*. New York, NY: Routledge.

Carroll, L., Gilroy, P. J., & Ryan, J. (2002). Transgender issues in counselor education. *Counselor Education and Supervision*, *41*(3), 233–242. doi:10.1002/j.1556-6978.2002.tb01286.x

Downloaded by [North Dakota State University] at 13:54 27 February 2013

Coolhart, D., & Torres Bernal, A. (2007). Clinical update: Transgender in family therapy. *Family Therapy Magazine*, *6*(3), 36–42. doi:10.1002/j.1556-6978.2002.tb01286.x

Council on Social Work Education. (2008). *Educational policy and accreditation standards*. Retrieved from http://www.cswe.org/File.aspx?id=13780

Creswell, J. W. (2007). *Qualitative inquiry and research design: Choosing among five approaches* (2nd ed.). Thousand Oaks, CA: Sage.

Dahl, C., & Boss, P. (2005). The use of phenomenology for family therapy research. In D. H. Sprenkle & F. P. Piercy (Eds.), *Research methods in family therapy* (2nd ed., pp. 63–84). New York: Guilford.

Embaye, N. (2006). Affirmative therapy with bisexual transgender people. *Journal of Bisexuality*, *6*, 51–63. doi:10.1300/J159v06n01_04

Emerson, S., & Rosenfeld, C. (1996). Stages of adjustment in family members of transgender individuals. *Journal of Family Psychology*, *7*(3), 1–12. doi:10.1300/J085V07N03_01

Eyre, S. L., de Guzman, R., Donovan, A. A., & Boissiere, C. (2004). "Hormones is not magic wands": Ethnography of a transgender scene in Oakland, California. *Ethnography*, *5*, 147–172. doi:10.1177/1466138104044376

Godfrey, K., Haddock, S. A., Fisher, A., & Lund, L. (2006). Essential training components for preparing therapists to work with lesbian, gay and bisexual clients: A Delphi study. *Journal of Marital and Family Therapy*, *32*, 491–504. doi:10.1111/j.1752-0606.2006.tb01623.x

Goldberg, J. M. (2006). Training community-based clinicians in transgender care. *International Journal of Transgenderism*, *9*, 219–231. doi:10.1300/J485v09n03_10

Grant, J. M., Mottet, L. A., Tanis, J., Harrison, J., Herman, J. L., & Keisling, M. (2011). *Injustice at every turn: A report of the National Transgender Discrimination Survey*. Washington: National Center for Transgender Equality and National Gay and Lesbian Task Force.

Grossman, A. H., D'Augelli, A. R., Howell, T. J., & Hubbard, S. (2005). Parents' reactions to transgender youths' gender nonconforming expression and identity. *Journal of Gay & Lesbian Social Services*, *18*(1), 3–16. doi:10.1300/J041v18n0102

Grossman, A. H., D'Augelli, A. R., & Salter, N. P. (2006). Male-to-female transgender youth gender expression milestones, gender atypicality, victimization, and parents' responses. *Journal of GLBT Family Studies* *2*(1), 71–92. doi:10.1300/J461v02n01_04

Hanssmann, C., Morrison, D., & Russian, E. (2008). Talking, gawking, or getting it done: Provider trainings to increase cultural and clinical competence for transgender and gender-nonconforming patients and clients. *Sexuality Research and Social Policy*, *5*, 5–23. doi:10.1525/srsp.2008.5.1.5

Hare-Mustin, R., & Marecek, J. (1988). The meaning of difference: Gender theory, postmodernism, and psychology. *American Psychologist*, *43*(6), 455–464. doi:10.1037/0003-066X.43.6.455

Hausman, B. (1995). *Changing sex: Transsexualism, technology, and the idea of gender*. Durham: Duke University Press.

Israel, G. E. (2005). Translove: Transgender persons and their families. *Journal of GLBT Family Studies*, *1*(1), 53–67. doi:10.1300/J461v01n01_05

Downloaded by [North Dakota State University] at 13:54 27 February 2013

Kessler, S. J., & McKenna, W. (1978). *Gender: An ethnomethodological approach*. New York: John Wiley and Sons.

Lev, A. I. (2004). *Transgender emergence: Therapeutic guidelines for working with gender variant people and their families*. New York: Haworth Press.

Lev, A. I. (2005). Disordering gender identity: Gender identity disorder and the DSM-IV-TR. *Journal of Psychology & Human Sexuality*, *17*(3/4), 35–69. doi:10.1300/J056v17n03_03

Lev, A. I. (2010). How queer!—The development of gender identity and sexual orientation in LGBTQ-headed families. *Family Process*, *49*(3), 268–290. doi:10.1111/j.1545-5300.2010.01323.x

Lincoln, Y. S., & Guba, E. G. (1986). But is it rigorous? Trustworthiness and authenticity in naturalistic evaluation. In D. D. Williams (Ed.), *New directions for program evaluation: Naturalistic evaluation* (issue 30, pp. 73–84). San Francisco, CA: Jossey-Bass.

Lombardi, E. (2009). Varieties of transgender/transsexual lives and their relationship with transphobia. *Journal of Homosexuality*, *56*(8), 977–992. doi:10.1080/00918360903275393

Lorber, J. (1994). *Paradoxes of gender*. New Haven, CT: Yale University Press.

Maguen, S., Shipherd, J. C., Harris, H. N., & Welch, L. P. (2007). Prevalence and predictors of disclosure of transgender identity. *International Journal of Sexual Health*, *19*, 3–13. doi:10.1300/J514v19n01_02

Moustakas, K. (1994). *Phenomenological research methods*. Thousand Oaks, CA: Sage.

Murphy, M. J., Park, J., & Lonsdale, N. J. (2006). Marriage and family therapy students' change in multicultural counseling competencies after a diversity course. *Contemporary Family Therapy: An International Journal*, *28*(3), 303–311. doi:10.1007/s10591-006-9009-8

Oswald, R., Blume, L., Berkowitz, D., & Kuvalanka, K. (2009). Queering "the family." In S. Lloyd, K. Allen, & A. Few (Eds.), *Sourcebook of feminist family studies*. Thousand Oaks, CA: Sage.

Piper, J., & Mannino, M. (2008). Identity formation for transsexual individuals in transition: A narrative family therapy model. *Journal of GLBT Family Studies*, *4*(1), 75–93. doi:10.1080/15504280802084472

Rachlin, K. (2002). Transgender individuals' experiences of psychotherapy. *The International Journal of Transgenderism*, *6*(1). Retrieved from http://www.wpath.org/journal/www.iiav.nl/ezines/web/IJT/97-03/numbers/symposion/ijtvo06no01_03.htm

Raj, R. (2002). Towards a transpositive therapeutic model: Developing clinical sensitivity and cultural competence in the effective support of transsexual and transgendered clients. *The International Journal of Transgenderism*, *6*(2). Retrieved from http://www.wpath.org/journal/www.iiav.nl/ezines/web/IJT/97-03/numbers/symposion/ijtvo06no02_04.htm

Raj, R. (2008). Transforming couples and families: A trans-formative therapeutic model for working with the loved-ones of gender-divergent youth and trans-identified adults. *Journal of GLBT Family Studies*, *4*, 133–163. doi:10.1080/15504280802096765

Downloaded by [North Dakota State University] at 13:54 27 February 2013

Rock, M., Carlson, T. S., & McGeorge, C. R. (2009). Assessing CFT students' beliefs about sexual orientation and level of affirmative training. *Journal of Marital & Family Therapy*, *3*(2), 171–184. doi:10.1111/j.1752-0606.2009.00172.x

Rostosky, S. S., Korfhage, B. A., Duhigg, J. M., Stern, A. J., Bennett, L., & Riggle, E. D. B. (2004). Same-sex couple perceptions of family support: A consensual qualitative study. *Family Process*, *43*, 43–57. doi:10.1111/j.1545-5300.2004.04301005.x

Saeger, K. (2006). Finding our way: Guiding a young transgender child. *Journal of GLBT Family Studies*, *2*(3/4), 207–245. doi:10.1300/J461v02n03_11

Schilt, K., & Westbrook, L. (2009). "Gender normals," transgender people, and the social maintenance of heterosexuality. *Gender & Society*, *23*, 440–464. doi:10.1177/0891243209340034

Sedgwick, E. K. (1990). *Epistemology of the closet*. Berkeley, CA: University of California Press.

Shipherd, J. C., Green, K. E., & Abramovitz, S. (2010). Transgender clients: Identifying and minimizing barriers to mental health treatment. *Journal of Gay & Lesbian Mental Health*, *14*(2), 94–108. doi:10.1080/19359701003622875

The World Professional Association for Transgender Health. (2011). *Standards of care for the health of transsexual, transgender, and gender nonconforming people—7th version*. Retrieved from http://www.wpath.org/documents/Standards%20of%20Care%20V7%20-%202011%20WPATH.pdf

Downloaded by [North Dakota State University] at 13:54 27 February 2013